

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

131a

118247

Reg. Dist. No. 254

### 1. PLACE OF DEATH:

County Queen Anne  
City or town Rural Grasonville  
(If outside city or town limits, write RURAL and give nearest town)  
Now long in above place of death? 50 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Queen Anne  
City or town Rural Grasonville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2.(a) If veteran, name war World War I

### 3. (a) FULL NAME

William Raymond Conyer  
4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced Married

### 3. (b) Social Security Number

218-09-7300

### 6. (b) Name of husband or wife Bernie Elizabeth Conyer

6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) September 2, 1897

8. AGE: Years 50 Months 27 Days 27 If less than one day  
hrs. min.

9. Birthplace Grasonville, Maryland  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Robert John Conyer

13. Birthplace Grasonville, Maryland

14. Maiden name Hanniet Conyer

15. Birthplace Grasonville, Maryland

16. Informant Bernie E. Conyer

Address Grasonville, Maryland

17. Burial Date thereof Oct. 2-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bryan Chapel Cemetery

Location Grasonville, Maryland

18. Funeral director John D. Williams

Address Easton, Md.

19. Oct. 2 1947 Helen M. Aldridge  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

2D. DATE OF DEATH September 29 1947 at 3:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to September 1947

and that I last saw him alive on September 29 1947

Immediate cause of death

Hypertensive Cardiovascular DURATION 5 yrs.

Renal Disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Conyer, MD M. D. or other

Address Queen Anne, Md Date signed Sept 29, 47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 7 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

## 1. PLACE OF DEATH:

County Queen Anne's  
 City or town Ruthsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 60 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Queen Anne's  
 City or town Ruthsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sarah Augusta Coursey

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband James L. Coursey  
 7. Birth date of deceased (mo., day, yr.) November 21 - 1866  
 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 80 Months 10 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Queen Anne's Co. Maryland  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Thomas Shembrooks

13. Birthplace Maryland

14. Maiden name Annus Hunter

15. Birthplace Queen Anne's Co. Md

16. Informant Mrs J. Sorden Peppin

Address Ruthsburg Maryland

17. Burial Date thereof Sept 28 - 47  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Chesterfield

Location Chesterfield Maryland

18. Funeral director Boston Bros

Address Chesterfield Maryland

19. 9-28- 47 Elmer Armetray  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 19 47 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to Apr. 21 19 47  
 and that I last saw him alive on Sept. 23 19 47

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Pneumonia 6 yrs

Due to \_\_\_\_\_

Due to Hypertension 7

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H. S. Matheson M. D. or other \_\_\_\_\_

Address Ruthsburg Md Date signed 9/26/47

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OCT 2 1947

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

932

08249

Reg. Dist. No. 251

### 1. PLACE OF DEATH:

County 22

City or town Barday Ind.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Def. 1/2

Hospital, institution, or street address where death occurred: 7a

How long in hospital or institution? 7a

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County 9a.

City or town Barday  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7a  
(If rural, give LOCATION)

2.(a) If veteran, name war 7a

### 3. (a) FULL NAME

Fannie Hall

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widow

8. (b) Name of husband or wife Thomas J. Hall

7. Birth date of deceased (mo., day, yr.) Aug 3 1865 8. (c) If alive, give age 78 years

8. AGE: Years 82 Months 11 Days 16 If less than one day hrs. min.

9. Birthplace Barday Ind.  
(Town, county, and state)

10. Usual occupation HV

11. Industry or business W. W. Slacky

12. Name W. W. Slacky

13. Birthplace 9a

14. Maiden name Lena Carson

15. Birthplace 9a

16. Informant Miss Lisa Barker

Address Barday Ind.

17. Burial Date thereof Sept. 23 - 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Templerdell

Location Templerdell Ind.

18. Funeral director Edgar A. Lane

Address Church Hill Ind.

19. Sept 23 47 Registrar Edgar A. Lane  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 19 47 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 19 47 to Sept 19 19 47 and that I last saw him alive on Sept 19 19 47

Immediate cause of death Death due to old age

Due to Chronic myocarditis

Due to Grand Arteriosclerosis

Other conditions Emphysema

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of Sept 19 47

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE D. Whitcomb

Address Richwood Ind. Date signed 9/23/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 2 1947

BUREAU 78



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of year of birth shown on FILM No. G 113 NOV 6 - 1947 is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change  
of year of birth shown on

FILM No. G 113 NOV 6 - 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH:

County Queen Anne's

City or town Stevensville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Queen Anne's

City or town Stevensville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(c) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

William P. Kirkwood

3. (b) Social Security Number

216-07-5275-

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Maudie

6. (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Feb 26 - 1878

8. AGE: Years 68 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore  
(Town, county, and state)

10. Usual occupation Store Police

11. Industry or business \_\_\_\_\_

12. Name Wm. P. Kirkwood

13. Birthplace Balt.

14. Maiden name Sarah Hanaker

15. Birthplace Ind.

16. Informant Mrs. Helen Kirkwood

Address Stevensville, Md

17. Burial Date thereof Sept 26 47  
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematorium Stevensville

Location Stevensville, Md

18. Funeral director Edgar J. Lane

Address Church Hill Rd

19. Sept 24 19 47 Elizabeth Hopton  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 19 47 at 8 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 18 19 47 to Sept 18 19 47

and that I last saw him alive on Sept. 18 19 47

Immediate cause of death \_\_\_\_\_

Coronary occlusion

Due to Arteriosclerosis

Due to Sclerosis coronary arteries

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Theodor Sattelmair M.D.

Address Stevensville Date signed 9/19/47

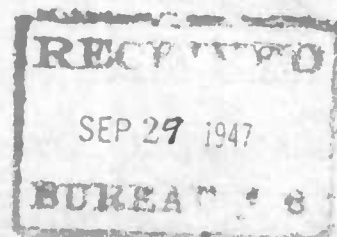
DURATION

Sept 18,

1947

General

yellow





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

95C08251

Reg. Dist. No. 254

## 1. PLACE OF DEATH:

County Queen Anne'sCity or town Princessville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town Princessville

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2. (a) If veteran, name war .....

## 3. (a) FULL NAME

Sarah Ann Stawman

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife George Stawman7. Birth date of deceased (mo., day, yr.) September 2-1874

8. AGE: Years Months Days If less than one day

73024

..... hrs. .... min.

9. Birthplace England

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James Savane Sawkin13. Birthplace England14. Maiden name Annie E. Rodgers15. Birthplace England16. Informant Mrs. Ida HaygooniAddress 2717 The Alameda Ball17. Buried Date thereof Oct 1-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ChestertownLocation Centerville Maryland18. Funeral director Barton BrosAddress Centerville Maryland19. Oct 1 19 47 Helen M. Alledge

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 19 47 at 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., 19....., 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death She was found deadin bed - on Sept 28 47 - 10 A.M.

She was treated by a doctor

about 3 mos ago for heart ailment

Due to.....

Essentially was a heart attack

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? .....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work?

23. SIGNATURE W. Henry FisherCenterville Md M. D. or otherAddress Centerville Md Date signed 9/29-47

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OCT 7 1947

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